Contact Lenses _____

Initials _____

CLINIC USE ONLY

COMMANDER'S AUTHORIZATION FORM

REFRACTIVE EYE SURGERY
WBAMC – FT BLISS
(To Be Submitted By ALL Applicants)

1. I give my permission for the following active duty Soldier to be considered for enrollment in the WRESP and for treatment if eligible.

_____

Patient Name (Print) (Last, First MI) Rank SSN

2. I certify the following to be true:
   a. **18 months** remaining in the **Active Duty Component**
   b. Minimum of **3 months** remaining at **Ft. Bliss** after surgery without deployment or PCS
   c. No adverse personnel actions pending including medical boards
   d. Will remain CONUS and is **non-deployable** for at least **90 days** post-surgery

3. I realize after refractive surgery the soldier will be on **convalescent leave for 6 days** and will have a physical profile as follows:
   a. For **one year** sunglasses must be worn outside during daylight hours
   b. For **one month** may not do the following: No driving or riding in a tactical vehicle, no driving of military/government vehicles after sun down, no swimming, no wearing of pro-mask, no face paint, no organized PT. No contact sports. No combative training. No aerobic activity that generates perspiration as to avoid concentrated sweat entering the eyes. No NBC training to include gas chamber or riot control agents. No working in sunny, windy, dusty areas, and non-climate controlled areas. No non-climate controlled living environment (i.e. tents). No firing of any weapon system or exposure to live fire. **Not to deploy/mobilize 90 days from the date of surgery.** No small pox vaccination.

4. Participation in the Warfighter Eye Surgery program requires some time investment resulting in absence from duty. The soldier **must** keep all scheduled appointments. Typical time requirements are as follows:
   a. Initial eye exam – up to half a day
   b. Surgery – 1 week off work
   c. Post-operative exams – 5 visits scheduled during the first year

5. This authorization form is good for 90 days from the date it is signed. If surgery is not completed within that time, a new form will need to be submitted.

6. It is the sole responsibility of the commander to ensure all requirements are met especially 18 months remaining on active duty.

7. I understand the information above and hereby give my permission/endorsement for this soldier to be evaluated and considered for enrollment in the Warfighter Eye Surgery Program and to have laser eye surgery if eligible.

_____

Commanders Name and Rank

_____

Commanders Signature

_____ _____

Date Phone number

WBAMC – Ft. Bliss
Refractive Eye Surgery Clinic
(915) 742-7051

EDITION FEB 2015

WBAMC - WRESP PATIENT HISTORY QUESTIONNAIRE

Last name | First name

Age | Date of Birth | Sex ☐ Male ☐ Female

Duty Title or Occupation | ETS date

Are you likely to Deploy, PCS, attend School or otherwise leave Ft. Bliss in the next 6 months? ☐ Yes ☐ No

Duty Status
☐ Active ☐ Reserves
☐ National Guard ☐ Other
☐ Active Guard Reserves

Special Duty
☐ None ☐ Ranger
☐ Airborne ☐ Air Assault
☐ HALO ☐ Aviation/Flight
☐ SCUBA ☐ Other
☐ Special Operations

List some of your hobbies and activities that require visual needs:
(Example: computers, sports, etc.)

1. _____
2. _____
3. _____

What do you hope to achieve from this surgery that will enhance your lifestyle and military job performance?
(Example: "Field exercises without glasses getting dirty/broken")
(Example: "Play sports without glasses falling off")

1. _____
2. _____
3. _____
4. _____

ALLERGIES

Are you allergic to any medications?	☐ Yes	☐ No
Have you ever had a reaction to: percocet, codeine, or hydrocodone?	☐ Yes	☐ No

MEDICATIONS

Are you taking any of the following medications?

Accutane (isotretinoin)	☐ Yes	☐ No
Birth control pill	☐ Yes	☐ No
Cordarone (amiodarone)	☐ Yes	☐ No
Immunosuppressants	☐ Yes	☐ No
Imitrex (sumatriptan)	☐ Yes	☐ No
Steroid medication	☐ Yes	☐ No
Do you currently take any medications?	☐ Yes	☐ No

Please answer the following questions carefully and explain any "Yes" answers in the box below.

OCULAR HISTORY

Do you or have you ever had the following?

Eye surgery or laser treatment	☐ Yes	☐ No
Eye injury or trauma	☐ Yes	☐ No
Told **not** candidate for Lasik/PRK	☐ Yes	☐ No
Dry eyes	☐ Yes	☐ No
Recurrent conjunctivitis	☐ Yes	☐ No
Corneal ulcer/infection	☐ Yes	☐ No
Corneal scar	☐ Yes	☐ No
Herpes eye infection	☐ Yes	☐ No
Keratoconus	☐ Yes	☐ No
Cataract	☐ Yes	☐ No
Glaucoma or high eye pressure	☐ Yes	☐ No
Retina problems	☐ Yes	☐ No
Poor vision even with glasses	☐ Yes	☐ No
Thyroid eye disease	☐ Yes	☐ No
Iritis/uveitis	☐ Yes	☐ No
Ocular rosacea	☐ Yes	☐ No
Chronic eye pain	☐ Yes	☐ No
Glare/halos around lights	☐ Yes	☐ No
Double vision	☐ Yes	☐ No
Amblyopia or lazy eye	☐ Yes	☐ No
Crossed eyes or eye misalignment	☐ Yes	☐ No
Eye patching or eye exercises	☐ Yes	☐ No
Problems wearing glasses, contacts	☐ Yes	☐ No
Reading glasses or glasses with bifocal or prism	☐ Yes	☐ No
Any chronic eye problems or disease	☐ Yes	☐ No
Family history of eye problems (excluding eyeglasses)	☐ Yes	☐ No

MEDICAL HISTORY

Do you or have you ever had the following?

Arthritis	☐ Yes	☐ No
Breathing problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Pacemaker or heart device	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Migraines or chronic headaches	☐ Yes	☐ No
Immunosuppression/HIV	☐ Yes	☐ No
Lupus or autoimmune disease	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No
Fibromyalgia-chronic pain syndrome	☐ Yes	☐ No
Poor wound healing	☐ Yes	☐ No
Claustrophobia	☐ Yes	☐ No
Immunizations in past 3 months	☐ Yes	☐ No
Skin problems: psoriasis or vitiligo	☐ Yes	☐ No
Any chronic medical conditions	☐ Yes	☐ No
(Females) Pregnant or nursing now or in the past 6 months	☐ Yes	☐ No

Explain any "Yes" answers from above:

Last Name	First Name	Rank/Grade	Today's Date

SSN	Email address (one you check on a regular basis)	Your Primary phone number

UNIT	Duty Phone	MOS

Emergency Contact Person	Phone	Relationship

How many years have you worn glasses?	How old are your current eyeglasses?	
How long have your worn contacts?	Last worn?	Brand ☐Soft ☐Rigid

I, _____ (Name) am requesting an evaluation for laser refractive eye surgery at William Beaumont Army Medical Center. By signing below I confirm that I have read and understand the following critical information concerning refractive eye surgery:

1. Certain medical or eye conditions may exist that can disqualify you from having surgery. You may be disqualified or you may withdraw from having surgery at anytime during the pre-operative process. Your doctor will make the final decision on whether you have surgery and what type of surgery (Lasik or PRK).

2. You must not have contact lenses in your eyes for **one month** prior to your pre-operative eye exam and surgery. Not complying may adversely impact the surgical result.

3. You must be available to see us for at least 3 months (but preferably 12 months) of post-operative care (no PCS, deployment, etc in that time frame). You will be required to return for all scheduled post-operative appointments.

4. To be considered for surgery, you must be at least 21 years old, have 18 months before ETS and be Active Duty assigned to an Active Duty unit and not Reserve or National Guard activated or otherwise.

5. You must bring the following to your pre-operative eye exam: current eyeglasses and any available prior eyeglass prescriptions.

6. (Females) You must not be pregnant or nursing 6 months before or after refractive eye surgery as it could adversely impact the surgical result.

7. You must have an escort/driver with you the day of surgery. You will be on con-leave and have a profile after the surgery as outlined on the Commander's Authorization Form.

8. You are not eligible for surgery if you have any adverse actions pending (ie: flag, chapter, medical board, UCMJ, etc).

9. If you are on special duty status now or in the future (ie: flight status, special forces, diver, etc) you must confirm with your unit surgeon that you are eligible for refractive eye surgery and see if any waivers or authorizations are required.

10. The Commander's Authorization Form must be signed and completed before consideration for surgery. The form expires 3 months after signature and if no surgery in that timeframe, will have to be resubmitted.

11. You may still need glasses or contacts after refractive eye surgery for your best vision.

(Signature) _____ (Date) _____

WBAMC
Refractive Eye Sugery Center
(915) 742-7051

For more information on refractive eye surgery,
please visit:
http://www.refractiveEyesurgery.org